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OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS: HEALTH SYSTEM FINANCING IN AFRICA

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WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DA SAÚDE
SEDE REGIONAL EM ÁFRICA

OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS: HEALTH SYSTEM FINANCING IN AFRICA

This document reviews the existing patterns of health system financing in the Region. This is a subject of particular importance to policy makers and the general public in view of the growing economic constraints and the increasing magnitude of health problems. Far from meeting the demand for health services, the regions' health systems are also having difficulty maintaining acceptable standards of health care.

A three-pronged approach has been adopted in this document: First, how can the very limited and diminishing resources be better managed or utilized to achieve better results, wider coverage and equity? Second, given the very limited budgetary resources, what are the alternative sources of funds and other resources? Third, how are the best affordable and effective technologies selected under the circumstances? The crucial issue is the effectiveness of the system.

Following a review of the causes and effects of major problems of financing health systems of the Region such as inadequacy of funds, maldistribution of health resources, technological options in the face of rising health costs, this document proposes a number of approaches for strengthening the national capacity and alternative strategies for generating and mobilising resources. The advantages and disadvantages of each strategy are considered in the light of various experiences in the Region.

Finally, a model for health system financing is proposed based upon the identified parameters. An outline of the model is presented.

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OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS: HEALTH SYSTEM FINANCING IN AFRICA

I. INTRODUCTION

1. Health system financing has been given increasing attention since the Alma-Ata Declaration in 1978 and the world economic crisis which began in 1983. The severe economic constraints and the apparent incapacity of governments of Member States to cope with the ever increasing demand for health care make the subject of particular concern to policy makers and the general public in the Region. Approaches to a review of health system financing are, under the circumstances, three-fold. First, how can the very limited and diminishing resources be better managed or utilized to achieve better results, wider coverage and equity? Second, given the very limited budgetary resources, what are the alternative sources of funds and other resources? Third, how does the health care system select for its clients the best affordable and effective technologies?

2. It is important to note that health system is not limited to health care alone; it includes the available preventive and curative services of the Ministry of Health and health-related activities of other ministries. Every Government is concerned about the health of its citizens and the financing of its health system; but it does not necessarily finance every aspect of the system. In this context, even the richest countries are desperately looking for ways and means of containing the costs of growing public needs and expectations.

3. Economic constraints have led to ad hoc or "unplanned" introduction, or raising, of direct charges for publicly subsidized health care without adequate prior study of the problem and the possible implications of the steps taken. Such a step should normally be part of a predetermined policy to increase cost recovery and reduce financial burden on government. Many African States have recently introduced or raised fees substantially.

4. The effect of such changes on health status, especially of the most vulnerable groups, health services utilization patterns and overall revenue and expenditure, is still not clear. This new situation calls for more in-depth study and research on health care financing policies and financing mechanisms, efficiency and equity of existing resource allocations and practices. WHO has initiated a study of the effect of the introduction, or raising, of user charges in the Region and many Member States have already

expressed interest in the proposal. By and large, any step taken must be examined realistically by:

(a) taking into account the administrative, economic and political implications;

(b) ensuring an improvement in the prevailing situation regarding funding, utilization of resources and equity, and

(c) bearing in mind prevailing and changing patterns of disease and health care practices.

II PATTERNS OF HEALTH FINANCING

(a) Government budgetary allocations

5. Traditionally, governments of the Region are committed in principle through their Ministries of Health, to provide health care for all their citizens. In spite of economic constraints, attempts at direct government financing of health activities are, in varying degrees, still current. Government allocations are made for the health sector in two possible ways; from overall government tax revenue and by designating revenue from certain special taxes (such as taxes on cigarettes and alcohol) to health care. In recent years, however, many governments have had to reduce overall public expenditure in real terms, because of the economic situation and fall in national revenue.

6. Annex 1 gives a breakdown of health expenditure, percentage of GNP spent on health, and percentage of health expenditure devoted to primary health care. Annex 2 shows the percentage of government expenditure on health, education and other economic and social sectors. Many countries spend as low as 1% of GNP on health. Regarding public expenditure, only three countries spend as much as 5%. Between 1972 and 1986 only two countries increased their percentage of expenditure on health, namely, one from 5.5% to 6.9% and the other from 6.3% to 8.3%. A model country which spent as much as 10.3% of its expenditure on health in 1972, declined 7.7% in 1986. Proportion of public expenditure for health in the Region decreased from 6.1% in 1972 to 3% in 1982. It is estimated that the current figure is far less.

7. Annex 2 shows that the declining economic growth and inflation is accompanied by a fall in the percentage of expenditure on health vis-a-vis other sectors. Obviously, health has been a low priority sector in the Region, and health budgets are victims of structural adjustment policies.

The possibility of either diverting resources from other sectors or increasing the proportion to be allocated to the health sector is therefore remote under the prevailing economic situation. The system is grossly underfinanced. Consequently, it is characterised by low wages, idle assets that cannot be maintained, shortages of drugs and other essential supplies, all of which tend to make the system ineffective.

8. On the average over 50% of health allocations in the Region are made to urban hospital centres. In one country, for example, 12% of the population in urban centres use up 35% of the recurrent health budget. About 60% of Region's health budgets is spent on salaries and wages of personnel; about 30% on the purchase of drugs and supplies and only 4.8% on maintenance and running costs. The proportion spent on capital investment and development of infrastructure and new facilities is generally less than 10%.

9. Governments have been unable to give due consideration to investment to cope with the rapid growth of population, the changing innovations and technology in health science, the increasing incidence of health disasters and the need for wider coverage and effectiveness. The proportion allocated to maintenance and running costs must be adequate to minimize instances of idle or ineffective assets. In fact, maintenance and effective utilisation of existing assets should take precedence over new investments. It is not rational to buy new assets if existing ones cannot be maintained. Overstatting accounts for the high proportion of recurrent budget on wages. Many of the statt are either insufficiently or inappropriately trained or underutilized, ineffective and frustrated because of shortages of running costs, drugs and equipment.

10. To the general public, availability of drugs determines the utilization of health services. When stocks are exhausted, visits to health centres are minimal; the staff and facilities are underutilized. But when stocks are replenished, the centres are crowded. The preferential budgetary allocation to urban centres cannot be justified from the view points of equity, economic rationale, epidemiology and effectiveness. There is therefore the need to pay more attention to health development in the rural areas, especially at the district level.

(b) Nongovernment financing

11. It is important to reiterate that budgetary allocations to the health sector is only one aspect of health system financing. Nongovernmental agencies

and individual household expenditure contribute to the financing of health and health-related activities, in varying degrees in different countries. In one country for example, government sources accounted for 23% as against individual financing of 63% and, external donations of 12% of total and 85% of capital expenditure in 1986. In another, mission hospitals and centres provide almost 40% of the health care.

12. The following is the estimated current pattern of health system financing in the Region.

Governmental sources	45.6%
Household expenditure and direct payments	16.1%
Foreign aid	33.2%
Employers (private companies)	3.8%
Missions and charity	1.3%

The item on household expenditure does not take into account voluntary efforts and services in the construction of wells, health centres and in the running of community health committees and so forth. Also, "government sources" does not include health-related activities carried out by other ministries.

13. The following estimated pattern of individual and household expenditure in the Region. It shows percentage of funds paid to -

Private hospitals and doctors (including missionary hospitals and centres)	40.9%
Government hospitals	24.0%
Drug sellers	21.0%
Traditional healers	7.0%
Health centres	4.9%
Others	0.2%

It is estimated that about 90% of individual and household expenditure is on curative services. The trend has been towards lower governmental financing and higher individual participation. Fees or charges in respect of traditional healers may be in cash or in kind. The substantial increase in user charges for government provided health care in one country in 1985 resulted in more intensive use of private, unlicensed drug salesmen and self medication.

14. The following broad conclusions can be drawn from the patterns described in the preceding paragraphs:

(1) Foreign aid constitute a major share of health system financing in the Region, but it is geographically selective and includes non-operational services such as training and education, research and advisory services. The relatively high salaries of international staff is included in the bill.

(2) The low contribution of employers is due not only to insufficient efforts by employers but also reflects the small proportion of population employed in the modern sector of the regions' economies. Increase in this respect will depend largely on the expansion of the sector.

(3) Drugs represent a major item of expenditure for governments, individuals and private hospitals. In spite of the fact that drugs are imported duty free in many countries, there is increasing disquieting evidence of dumping of faked and expired drugs.

(4) The coverage of the rural areas, the urban centres and the poor is still inadequate in many countries. The inadequacies of health services is not compensated by the fact that a substantial proportion of people rely on traditional healers and unlicensed drug pedlars.

(5) Inadequacy of data, statistics and preliminary studies constitutes a major constraint. Consequently, planning and budgeting are often based on guess work. There is also the problem of establishing well founded priorities under the circumstances.

III PROBLEMS OF FINANCING HEALTH SYSTEMS

(a) Inadequacy of funds

15. Funding is a major constraint. The preceding chapters have emphasised the inadequacy of funds and the low priority accorded the health sector of the Region. Less than 3% of public expenditure is currently allocated to health as compared to over 12% in the developed countries*. Budgetary allocations and foreign aid are diminishing in real terms almost as fast as health

* Source: World Bank World Development Report, 1985.

disasters and health needs are increasing. Even the maintenance of existing facilities and immediate post independence standards are not being met. The resources are just not there to cover effectively a substantial proportion of the people. To achieve the goal of Health for All by the Year 2000 would require innovations in mobilising the necessary resources.

16. Countries which have entrenched free health care in their constitutions and others which have opted for free health care for all earning less than a defined minimum wage are experiencing great hardship in keeping to their commitments. There is the additional problem of finding the necessary foreign exchange to meet health needs.

(b) Maldistribution of health resources

17. The maldistribution of resources is as serious, if not more, as the inadequacy of funds. The preceding chapter on patterns of financing shows clear bias in favour of:

(i) urban centres vis-a-vis rural areas where the vast majority of the population live;

(ii) the relatively rich vis-a-vis the poor who have limited access to health care and can least afford it;

(iii) curative services as against preventive services;

(iv) personnel salaries and wages vis-a-vis investment in health development and infrastructural facilities; and

(v) the purchase of new and "high tech" equipment as against the maintenance of existing facilities and the provision of funds for spare parts.

In general, there is a need for a more equitable distribution of resources and carefully prepared masterplans highlighting priorities and more clearly defined objectives .

18. The view point of equity requires attention. How can the very meagre resources be stretched to cover effectively the poor masses and those who pay the taxes or provide the resources? In most countries of the Region, this is an impossible task. There is also the view that what is worth doing at all is worth doing well. One runs the risk of spreading the meagre resources too thinly across that the end result is calamitous. Both view points need to be borne in mind.

(c) Rising health costs

19. Statistics shows that the cost of health services has risen much faster than the cost of living in both the developed and developing countries. Rising health costs constitute a major problem in health system financing in the Region, considering:

(i) the high rate of inflation;

(ii) the deteriorating national earnings and income per capita, in real terms;

(iii) the fact that most of the drugs and equipment have to be imported and paid for in foreign exchange; and

(iv) frequent devaluation of currencies in many of the Member States.

(v) high local demand in view of high rate of population growth and increasing health hazards.

For example, in one country (as in many other countries) 1000 tablets of imported chloroquine rose from Sh.170 in 1986 to Sh.1300 in 1988. This dramatic rise reflects increases in both dollar and shilling terms.

(d) Management

20. For a region with meagre resources, good management is of paramount importance. It determines effectiveness. There are innumerable instances of overstaffing, misuse of funds, drugs and instruments, and underutilization of resources in many health systems of the Region. Basic management issues such as inadequate records, poor stock and stores control and poor planning may result in poor allocation of resources and wastage. Clear definition of functions and responsibilities, cost consciousness and public accountability at all levels and the establishment of an adequate monitoring and evaluation systems are some of the essential pre-requisites for effective utilisation of the diminishing resources available to the health sector.

21. Perhaps more important is the need for more effective coordination between national health care institutions. It has not always been easy to coordinate health activities within the public sector not to mention coordination in both public and private sectors. In the public

sector, for example, there is need to coordinate the activities within the health sector, between the health ministry and the other ministries and promote a dialogue between the providers and users of health services. Problems of coordination become more complex when there are different sources of finance. With the growing tendency towards decentralisation and, in some countries, greater private sector participation, the need for coordination is becoming more pronounced. The guiding principle is that efforts at every level should be in accord with the national health strategy. The same is true of external technical assistance that should, at its best, complement the national health system.

IV PROPOSALS FOR REMEDY

(a) Strengthening national capacity to finance the health sector

(i) Public sector budget

22. First and foremost, the low priority accorded the health sector of the region needs to be reviewed by the various governments. At the 34th World Health Assembly in 1987, 5% of GNP was set as the target for countries aiming at Health for All by the Year 2000. Adherence to this target will enhance the leadership role of government, encourage further private sector participation, stimulate involvement of communities, and foster a self-reliant and self sustaining health system.

23. Apart from general tax revenues, the national capacity for government spending in the health sector can be realistically enhanced by:

(i) earmaking special taxes on items such as entertainment, alcohol and cigarettes for health care of vulnerable groups in rural and urban areas;

(ii) ensure that funds from other sectors (especially agriculture, food and nutrition, public works, housing, water supplies, education, public information) effectively promote health and reduce disease burden;

(iii) charging fees for services rendered under a cost-recovery scheme and reinvest these in the health system.

Each of these approaches requires careful study of its possible implications before any decision is taken. The competing demands are always so strong that

marginal increases in government allocation, if any, are likely to meet with resistance. In a number of countries, a proportion of fees/taxes collected at the local level is retained for local health and other services. However, so much depends on the overall national priorities and the capacity of the health sector to convince planners that health is a productive activity - it produces healthy people (work force) and keeps them in good health.

(2) Investment policy

24. It is noted in paragraph 8 that less than 10% of government budgetary allocation is earmarked for capital investment and development of infrastructure and new facilities. For a Region with the fastest population growth in the world (3.2% annual growth) and low health status, inadequate investment constitutes yet another major problem. Because of the high rate of growth, the population is young and this enlarges the size of the vulnerable group.

25. To maintain existing standards of living (and health care), economists work on the premise that a nation needs at least 4% of the national income as investments to meet the requirements of one percent of annual population growth. For a nation with 3% population growth, this amounts to 12%. Although this would be unrealistic at this time, it is proposed that selective investments in health development should be accorded top priority. Investments are crucial for public security and will enhance the system's capacity:

(i) to cope with the population growth, especially for mothers and babies;

(ii) to attain significant improvements in standards and wider coverage of disease control services; and

(iii) to fill significant gaps in the health infrastructure, especially at the local level.

(3) Selection of affordable technologies

26. Technology can be defined as "an association of methods, techniques and equipment together with the people using them*". Technologies may be traditional or modern (i.e. recently discovered), in either case, local or imported. Obviously, traditional locally available technologies are more likely affordable than modern or imported. Policy makers and consumers would, however, be concerned with effectiveness, since the latter would in the long run be economical.

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* WHO/HFA Series No.8, page 8

27. Use of technologies would depend upon the levels of the health care system; most highly qualified and specialized usually find themselves (justifiably or not) at the apex of the system; the less qualified who are most numerous occupy the base of the pyramid, close to where people live and work.

28. Decentralization is an inevitable feature of such a system, the principle being that no one undertakes tasks which can be performed as well by less qualified, less costly personnel. It is important to emphasize that the simplest and most affordable technologies can and do resolve the most prevalent health problems; more complex and more expensive technologies are reserved for more difficult but less common problems. It is vital that each country, or a subregion including a number of relatively small countries, be self sufficient technologically; and that access to health care be equitably distributed.

29. This does not mean that national medical centres in the capital cities or those in provincial capitals should not be fully equipped. But such "high tech." should be accessible to those unfortunate few who need it wherever they live. A judicious selection and distribution of affordable technologies for primary, secondary and tertiary care would result in effective health care at minimum cost. Operational Research and continuing education are crucial for technology selection and adaptation to local circumstances.

(c) User charges

30. In view of the constraints on financing the health system, a number of Member States are known to have introduced or raised fees for health services in recent years. They include the Republic of Benin, Ghana, Niger, Rwanda, Madagascar, Mozambique, Botswana, Nigeria and Liberia. A few others are considering doing so. However, as pointed out in paragraph 4, very little is yet known about the effect of such measures on health status, the resulting change in health services utilization pattens and; most importantly, the effect on the vulnerable groups. There is also need to assess in each case the net revenue and the possible changes in the quality and coverage of services provided. These are crucial issues for health policy makers. WHO is taking necessary action to undertake a comprehensive study on the subject.

31. Nevertheless, user charges have several potential advantages apart from reducing the burden on government: (i) income generated can be utilised to develop other priority health services; (ii) services are more likely to

improve in quality if fees are retained at the community/district where they are collected; (iii) the introduction of fees will make users take more rational decisions on the use of health services. This will reduce unnecessary use of services and give health workers more time to improve the quality of care.

32. The possible disadvantages are equally striking: (i) the very people who are likely to benefit from the provision of health care service may not be in a position to afford the charges, others may use the service less because of the cost; (ii) users are more interested in paying for curative and "high-tech" services and the introduction of user charges may therefore tend to ignore preventive services and appropriate technologies such as immunization and oral rehydration; (iii) the overall increase in revenue may be so little after deducting administrative costs. Empirical studies are therefore necessary to determine the possible effects of user charges and the extent of fees to be charged.

33. In July 1985 fees were substantially raised in one country for the first time in over a decade. Each health unit retains a percentage of the fees collected and the balance is paid to the Treasury in accordance with the governments cost recovery system. Such fees now constitute 20% of the government revenue from non-hospital health facilities.

34. The immediate consequence of the increase in one district was an instant drop of over 50% in attendance at most health centres. Three years after, utilization of health centres rose to 30% of the pre July 1985 level. At the urban health units, utilization rate was restored to previous level within 18 months. But the level of utilization in the health units remained substantially low. Another outcome of the increase is that the rural population appears to be relying more on unlicensed drug salesmen, self medication, traditional healers and, at best, missionary hospitals where increases have been more gradual. The overall effect of the increase on health status in the rural sector is yet to be determined.

(d) Revolving Drug Fund

35. A variety of organisations ranging from communities, village health committees, welfare groups, cooperatives and local government authorities have been organised as the basis for running Revolving Drug Fund. Such a Fund ensures the reliability of supplies at a reasonable price and the maintenance of a stock of essential drugs. The Fund's principle is that expenses should

equal receipts from sales and all funds are recovered after making reasonable provision for losses and leakages. This scheme has been tried with varying success in some Member States.

36. In one country where the concept of user fees was introduced since 1979, there is a nation wide village health service system covering 298 villages. A fund, under the management of the Village Development Committee, is made up of proceeds from the sale of prescribed drugs. Drugs are purchased from the Regional Medical Stores. The government bears the costs of supervision and provides small annual grants to each Village Development Committee.

37. Another country which had free medical services until 1985, established the National Drug Service (NDS); a Revolving Fund that operates on the basis of "no money, no drugs". The government, however, earmarks some money to the health centres in respect of the vulnerable group. The NDS had a surplus of 9% in 1986 and 6% in 1987. Above all, utilization of health facilities increased by 19% in 1986 and 36% in 1987. The morale of staff has also improved since NDS began with stock provided by WHO, UNICEF and USAID. The reasons for the resounding success include: (i) constant availability of drugs; (ii) effective publicity; (iii) lower prices and (iv) favourable attitude of acceptance.

38. Similar success has been recorded yet in another country where the scheme was introduced in six districts and the western area in mid 1986. Here, success has been mainly due to its effective supply distribution logistics system, good planning and management and the introduction of simple but effective record keeping systems.

(e) The Bamako Initiative

39. The Bamako Initiative was formally introduced in September 1987 by African Ministers of Health of the Region. The main objective is universal accessibility to primary health care with emphasis on women and children by strengthening local financing and management. It is designed to encourage maximum community involvement through initial provision of basic essential drugs and supplies, the proceeds from which can be utilized to build up a system of user-financing and cost recovery and a revolving fund. This would be utilized in financing other components of the primary health care (especially for mothers and children), and to promote management capability at the district level.

40. In practice, the international community, through WHO and UNICEF, would provide the first consignment of drugs free of charge and the proceeds of the sale are used to restock the system, and create a revolving fund. Due consideration is given to the vulnerable groups. There are also special arrangements for communities that do not succeed with the initial stock of supplies. Although the project aims at making the community and the nation self-reliant, the international community has an important role to play by making foreign exchange available for the importation of essential drugs and providing necessary encouragement and support.

41. One country of the Region provides spectacular success stories of the Bamako Initiative type of projects with WHO and UNICEF support. Over 40% of the country's population is now covered under the system. Thirty-five non-governmental organisations bilateral and other multilateral organisations and missionary hospitals are actively implementing the Bamako Initiative approach. Panou, a community of 20 000, has been the show piece. Several missions have been undertaken by representatives of other communities or other countries to study the system. The approach is quite flexible and can be adapted to fit various communities. In October 1988, the Government enacted a law on Essential Drugs which will foster further Bamako Initiative in the country.

(f) Health insurance mechanisms

42. There are various insurance schemes to assist individuals to finance health services. Each of them involves the collection of funds or premium on a regular basis from the insurer in respect of the potential users (the insured), some are compulsory, others are voluntary. The money collected forms a pool which can be drawn upon in case of illness. A number of employers make such arrangements in respect of their workers. So far such schemes cover a minute fraction of the population. In one country, for example, health insurance covers only 22 000 employees in the private sector in 1982, out of a total population of 7.5 million.

43. Insurance contributions are easier to collect than tax. Contributors are also more willing to pay because of the evident benefits. Contributions vary according to people's income. This is an advantage from the equity point of view. There is considerable scope for the development of voluntary insurance schemes in rural communities of the Region.

V. A FRAMEWORK FOR HEALTH SYSTEM FINANCING

44. Annex 3 provides guidelines for the preparation of a three dimensional model for national health system financing. The proposed model takes account of the existing patterns and problems of financing health systems and the implications of alternative strategies for improving health system financing and effectiveness. The three dimensions adopted are (1) the major sources of funds, (2) the major items of expenditure and (3) the levels of health care activities - the central, intermediate and peripheral levels respectively.

VI. CONCLUSION AND RECOMMENDATIONS

45. Considering the prevailing economic constraints on governments, it is essential that alternative strategies for financing the health systems in the region be adopted after careful study of their implications by health authorities.

First, it is important that utilization of existing resources is cost effective. This involves better management and coordination and the development of efficient data collection system and statistics necessary for planning purposes and decision making.

Second, to ensure sufficiency of funds, alternative strategies must be carefully studied to ensure stable flow of resources, equity and accessibility of health care to all, particularly the vulnerable groups. Unexpected shortages of funds and drugs and non payment of salaries can destabilise the system. Care must be taken to see that the burden of health financing is fairly distributed and does not fall too heavily on any particular group.

Third, every strategy adopted should enhance utilisation of services, wider coverage of the population with primary health care and accelerate the attainment of Health for All by the Year 2000.

46. Substantial decentralisation and focus on the district level will facilitate wider coverage, efficiency and self-reliance. It is by far, the most effective way of mobilising resources in support of the health system. As the communities become more self-reliant, the public sector will also be expected to play greater leadership role by enhancing its efforts in areas of investments and the provision of the necessary infrastructural facilities, training and research, management and particularly coordination.

47. Pricing policy for drugs and determination of fees for services are absolutely critical. They must be such that they do not encourage over use or

misuse or underutilization of health facilities. Exemption policies are also difficult to administer and should therefore be limited. The larger the number of exemptions, the higher is the burden on the others under a full cost recovery scheme. Here consultation with the community or users is necessary to identify those to be exempted, to solicit their cooperation in collecting and safeguarding funds and to determine affordable rates or fees.

68. To attain self-reliance, local production of drugs and other health facilities need to be encouraged, especially in areas where the raw materials are available locally. This will entail intersectoral cooperation between the health and industry sectors. In some countries, the Department of Industry, in collaboration with the Department of Health, are engaged in the production of drugs using local medicinal plants.

69. Finally, the proposed Special Health Fund for Africa is yet another essential financing strategy that deserves attention.

Table 1

Health Expenditure

Country and area	GNP per head		Percentage of GNP spent on health		Percentage of health expenditure devoted to PHC	
	(US $)	Year	%	Year	%	Year
Algeria	2 320	1983				
Angola	470	1982				
Benin	290	1983	1.0	1983		
Botswana	6 480	1984	3.4	1984	48.0	1985
Burkina Faso	240	1982	9	1981		
Burundi	180	1984			30.0	1984
Cameroon	880	1982				
Cape Verde	317	1985	1.0	1981		
Central African Republic	280	1983	2.1	1985		
Chad	80	1984				
Comoros	300	1984				
Congo	1 230	1983				
Côte d'Ivoire	950	1982	1.4	1980		
Equatorial Guinea	180	1982				
Ethiopia	120	1983	1.8	1981	27.2	1984
Gabon	3 950	1983	2.7	1983	65.0	1983
Gambia	250	1983			7.0	1983
Ghana	310	1983				
Guinea	300	1984	1.5	1984		
Guinea Bissau	160	1983	3.7	1984	30.0	1984
Kenya	200	1983	2.1	1983		
Lesotho	623	1984	1.4	1984	43.0	1983
Liberia	520	1984	3.0	1983	23.0	1983
Madagascar	210	1983			61.0	1984
Malawi	262	1984	3.0	1984	46.0	1984
Mali	120	1983	1.0	1983	24.6	1984
Mauritania	185	1983	7.6	1984	59.9	1984
Mauritius	923	1983	3.0	1983		
Mozambique	270	1981	2.6	1983	40.0	1982
Namibia	1 410	1980				
Niger	240	1983			53.2	1984
Nigeria	770	1983				
Reunion	3 830	1980				
Rwanda	236	1981				
Saint Helena						
Sao Tome and Principe	264	1983	6.8	1983	45.0	1982
Senegal	440	1983				
Seychelles	2 224	1985	3.8	1984	17.0	1984
Sierra Leone	320	1984	6.7	1984	15.0	1984
Swaziland	940	1982			11.7	1984
Tanzania	270	1982				
Togo	264	1984	4.5	1982	50.0	1982
Uganda	230	1984				
Zaire	170	1983	2.5	1985		
Zambia	580	1983				
Zimbabwe	730	1983	2.6	1982	37.0	1982

Source: WHO/AFRO

Annex 2

Table

Central Governme

	Percentage of total expenditure						
	Defence		Education		Health		Housing amenitie social security welfare
	1972	1986	1972	1986	1972	1986	1972
Ethiopia	14.3	-	14.4	-	5.7	-	4.4
Burkina Faso	11.5	19.2	20.6	17.7	8.2	6.6	8.3
Botswana	0.0	6.4	10.1	17.7	6.1	5.0	21.5
Burundi	10.3	-	23.4	-	6.0	-	2.7
Cameroon	-	8.8	-	14.4	-	5.1	-
Chad	24.6	-	14.8	-	4.4	-	1.7
Congo	-	-	-	-	-	-	-
Côte d'Ivoire	-	3.9	-	20.5	-	4.0	-
Gabon	-	-	-	-	-	-	-
Ghana	7.9	6.5	20.1	23.9	6.3	8.3	4.1
Kenya	6.0	8.7	21.9	19.7	7.9	6.4	3.9
Lesotho	0.0	9.6	22.4	15.5	7.3	6.9	6.3
Liberia	-	7.7	-	14.2	-	5.7	-
Madagascar	3.6	-	9.1	-	4.2	-	9.9
Mali	-	8.1	-	9.0	-	1.7	-
Malawi	3.1	6.0	15.8	11.0	5.5	6.9	5.8
Nigeria	40.2	-	4.5	-	3.6	-	0.8
Mauritius	0.8	0.8	13.5	13.4	10.3	7.7	3.1
Rwanda	25.6	-	22.2	-	5.7	-	2.6
Senegal	-	-	-	-	-	-	-
Papua-New Guinea	-	4.5	-	17.0	-	9.6	-
Somalia	23.3	-	5.5	-	7.2	-	1.9
Sierra Leone	-	3.4	-	12.8	-	5.8	-
Sudan	24.1	-	9.3	-	5.4	-	1.4
Togo	-	6.9	-	11.7	-	3.6	-
Tanzania	11.9	13.8	17.3	7.2	7.2	4.9	2.1
Uganda	23.1	26.3	15.3	15.0	5.3	2.4	3
Zaire	11.1	-	15.2	-	2.3	-	1.0
Zimbabwe	-	15.2	-	20.9	-	6.2	-
Zambia	0.0	-	19.0	16.0	7.4	7.2	1.3

Source: The courier No.11

Expenditure

and		Economic services		Other		Total expenditure (% of GNP)		Overall surplus/ deficit (% of GNP)	
1986	1972	1986	1972	1986	1972	1986	1972	1986
-	22.9	-	38.3	-	13.7	-	-1.4	-
15.5	13.9	37.6	34.7	11.1	13.2	0.3	1.6	
7.3	27.9	29.7	34.3	34.0	33.6	49.4	-23.8	31.8
-	33.9	-	23.8	-	19.9	-	0.0	-
11.4	-	33.8	-	26.6	-	22.4	-	0.8
-	21.8	-	32.7	-	14.9	-	-2.7	-
-	-	-	-	-	-	-	-2.7	-
1.8	-	31.5	-	38.3	-	31.2	-	-3.1
-	-	-	-	-	40.1	41.0	-12.9	0.1
7.3	15.1	15.7	46.6	38.3	19.5	14.0	- 5.8	0.1
0.5	30.1	27.6	30.2	37.0	21.0	27.8	- 3.9	-6.7
1.5	21.4	25.5	42.7	41.0	14.5	24.2	3.5	-2.6
1.8	-	34.5	-	36.2	-	27.1	-	-9.0
-	40.5	-	32.7	-	20.8	-	-2.5	-
6.2	-	7.7	-	67.3	-	34.0	-	-9.6
1.9	33.1	30.5	36.8	43.7	22.1	31.5	-6.2	-8.4
-	19.6	-	31.4	-	10.2	-	-0.9	-
1.6	13.9	12.4	58.3	64.1	16.3	24.9	-1.2	-3.5
-	22.0	-	21.9	-	12.5	-	-2.7	-
-	-	-	-	-	18.8	-	-2.8	-
2.0	-	18.6	-	48.3	-	34.8	-	-2.6
-	21.6	-	40.5	-	13.5	-	0.6	-
2.0	-	15.4	-	60.4	-	13.6	-	-8.9
-	15.8	-	44.1	-	19.7	-	-0.8	-
9.2	-	23.5	-	45.2	-	42.3	-	-5.1
1.4	39.0	26.0	22.6	48.6	19.7	23.9	-5.1	-
0.8	12.4	18.8	36.6	40.7	21.8	9.4	-8.1	-2.8
-	13.1	-	56.1	-		-3.8	-	-
4.7	-	20.0	-	27.0	-	35.2	-	-7.0
2.6	26.7	16.1	45.7	58.3	34.0	38.2	13.9	16.3

HEALTH SYSTEM FINANCING: GUIDELINES FOR A MODEL

1. Objective

Health for All by the Year 2000.

2. Pre-requisites

1. Total national commitment towards attaining above objective ba high level of political will and determination.

2. National development plan, indicating adequate priority f health sector and assurance of adequate share of GNP.

3. National Health Masterplan

   (a) based on, and consistent with, the National Development Pl

   (b) must be politically, financially and administratively feas

   (c) must indicate national health policies and plan of action;

   (d) must include necessary financial projections on recurrent capital budgets and show relationship between them;

   (e) must be based on careful and detailed study of:

      (i) existing health structure and status, facilities, hea services utilization patterns and rates of coverage;

      (ii) overall health needs and population growth;

      (iii) the vulnerable groups.

   (f) must spell out the role of all concerned.

3. Criteria for model

1. Equity, with particular attention given to:

   (a) sharing the burden of the system fairly according to one's capability;

   (b) the vulnerable group in society, particularly the very po mothers and children and the neglected rural areas.

2. Adequate funding, consistent with a reliable revenue plan and providing carefully selected and tested incentives.

3. Effectiveness.

4. Intersectoral linkages and cooperation, particularly with:

   (a) other ministries responsible for health-related activities, such as water supply, housing, education and agriculture;

   (b) foreign technical assistance support.

4. Indicators for determining national capacity and attitudes

1. Gross National Product (per capita) is a positive indicator of national (particularly government) capacity.

2. Income per capita and distribution of income patterns are indicators of the capacity of individuals, communities or groups.

3. Low cost of living is also a positive indicator of individuals capacity.

4. Percentage of public health expenditure vis-a-vis other sectors is an indicator of decision makers' assessment of the importance of health in national socioeconomic development.

5. Proportion of private expenditure vis-a-vis public expenditure is an indicator of effort made by the private sector within the system. Conversely, it may also be a reflection of the inadequacies of state sponsored health institutions.

6. Revenue from fees for health services and other cost recovery schemes vis-a-vis the level of utilization of health services reveal the extent of receptiveness to increases (or introduction) of fees.

5. Three dimensional model

1. Sources of funds

   (i) Government budgetary allocation;

   (ii) Individual sources, including payment of fees for services, purchase of drugs, etc.;

   (iii) Community efforts, including other private sector groups such as companies;

   (iv) Local nongovernmental organizations such as missionary hospitals;

   (v) Foreign technical assistance, including unilateral, bilateral and multilateral sources.

2. Expenditure items

   (i) Health personnel salaries and wages;
   (ii) Drugs and supplies;
   (iii) Other running costs;
   (iv) Maintenance;
   (v) Capital investment;
   (vi) Training and research;

(vii) Subsidy for vulnerable groups;
(viii) Special fund for emergencies.

3. Resource allocation

(i) Central;
(ii) Intermediate;
(iii) Periphery, consisting of the vast majority of the population.

6. Guidelines for filling the table

1. Expenditure

The masterplan and national priorities will determine the weight to be placed on each expenditure item, after considering existing health funding pattern (HFP) and the desired HFP, taking an optimal number of correlated factors into account.

2. The sources of fund

The three sources of national revenue will be based on GNP, income per capita, distribution of income and empirical studies on the implications of additional fees or charges on each group. The amount of technical cooperation can be pre-determined in accordance with commitment to assist on the basis of the masterplan. It is assumed that foreign support will foster self-reliance and complement national effort.

3. Allocations to central, intermediate and periphery levels

This will depend on population distribution, distribution of income and the neglected areas.

8. Limitation of model

This model does not reflect:

(a) expenditure for curative as distinct from preventive and promotion of health activities - however, the distinction must not be overlooked in determining government budgetary allocations and foreign technical cooperation activities;

(b) payments in kind and material and voluntary support;

(c) expenditure on health-related sectors.

FRAMEWORK FOR HEALTH SYSTEM FINANCING MODEL

EXPENDITURE	LEVEL	SOURCE					TOTAL
		Government	Individual	Community	Local NGOs	Foreign Aid	
Salaries	Central						
	Interm.						
	Periph.						
Drugs & Supplies	Central						
	Interm.						
	Periph.						
Maintenance	Central						
	Interm.						
	Periph.						
Other running costs	Central						
	Interm.						
	Periph.						
Capital investment and new infrast.	Central						
	Interm.						
	Periph.						
Training and research	Central						
	Interm.						
	Periph.						
Subsidy for vulnerable groups	Central						
	Interm.						
	Periph.						
Emergencies	Central						
	Interm.						
	Periph.						
TOTAL	Central						
	Interm.						
	Periph.						

	Total						

7. Africa's population is young, as reflected in a median age of 17.3. This compares with a median age of 21.0 years in less developed regions, 23.5 years for the world, and 32.5 years in more developed regions. Children, i.e., those aged 0-14, constitute 45 per cent of the total population in Africa, youths (those aged 15-24) 19 per cent, the 15-59 year age group 50.2 per cent and the elderly (60 years and over) 4.8 per cent. These figures mean that Africa is handicapped by the highest dependency ratios, despite the lowest proportion of elderly people, although the absolute number of old people is increasing. As mortality rates improve, so the population is slowly ageing.

8. Africa's population growth rate, which was less than 2.2 per cent in 1950, is currently around 3 per cent per annum and this will not change much to the turn of the century. At this rate, the population will double in size in 23 years to reach about 1.26 billion by the year 2 012. At that time, Africa's population growth rate may reach a level higher by 1.8 per cent than that of the world as a whole and 5.7 times higher than the rate of the more developed regions (see table 2).

9. West Africa has the highest growth rates followed by Eastern Africa, Middle Africa, North Africa and then Southern Africa. Both the young population age structure and the high population growth rates have implications for the provision of social services and amenities such as education, employment, health, food, housing, etc., as will be discussed in section III.

B. Fertility

10. Fertility in Africa has been the highest in the world since 1950 when the crude birth rate was 49 per 1,000 as compared with an estimated 45 per 1,000 today. Between 1995-2000 little change is expected in its decline. As shown in table 3, Africa's present crude birth rate is about three times that of the more developed regions. Variations exist in the crude birth rates among the subregions in Africa and they follow a similar pattern to population growth rates.

11. Fertility can be examined in terms of total fertility per woman, as shown in table 4. Between 1950-1955 and a woman had averaged 6.6 children, current estimates are 6.2 children per woman, i.e., a decline of only 6 per cent over some 40 years. Thus fertility has remained very high and almost unchanged for many years. Some decline, however, may be expected by the turn of the century. The total fertility figure of 6.2 compares with 3.4 for the world, 1.9 in more developed regions and 3.9 in less developed regions.

C. Mortality

12. Nearly all Governments in Africa are concerned about high mortality rates and strive to reduce them. The crude death rate (i.e., the number of deaths per 1,000 population), fell by about 45 per cent from 27.0 in 1950-1955 to the present estimates of 14.9. Although this is a significant decline, the rates are still the highest in the world. By the turn of the century, the crude death rate is expected to decline to 12 for the continent, as shown in table 5.

I. INTRODUCTION

1. The mid-term review of the implementation of the United Nations Programme of Action for African Economic Recovery and Development revealed that, in spite of the tremendous efforts by governments to cope with the socio-economic problems, the situation continued to worsen, as a result of the combined action of many factors, which are not within the scope of this paper. Suffice it to indicate that population trends in Africa contribute to the overall picture. Document A/43/500, on the critical economic situation in Africa, submitted to the forty-third session of the General Assembly, clearly highlighted the population problem (paras. 83 to 85).

2. The purpose of this paper is to present the demographic trends in Africa and their implications for the implementation of the UN-PAAERD. It will also discuss some issues related to policies, as generally perceived and implemented by member States. Clearly, the life span of five years for the Programme of Action is too brief for action undertaken within its framework to bear significant results on population trends. Both past policies and present ones have their impact on the dynamics of population, however, and they have consequences on the development objectives in all countries. It is necessary, therefore, to consider the trends from 1950 in order to understand fully the contemporary situation and give the right framework for the consideration of the population dimension.

3. The Kilimanjaro Programme of Action (KPA), now five years old, recognizes that population is a central component in formulating and implementing policies and programmes for socio-economic development. It addresses all aspects of population changes and constitutes the main reference for the recommendations geared to action in this field. This has been acknowledged in both Africa's Priority Programme for Economic Recovery (APPER), 1986-1990 and the United Nations Programme of Action for African Economic Recovery (UN-PAAERD).

II. PAST, PRESENT AND FUTURE POPULATION TRENDS

4. The 1988 United Nations Assessment on Population and the 1987 Monitoring Report on World Population Trends and Policies give the latest available data and estimates for reviewing past and future trends and the current situation. Selected variables are considered, including population size, structure, growth rates, fertility, mortality, distribution and internal migration and population-related policies.

5. International migration was not included in the review, as it is a significant problem for only a few countries. Intra-African migration certainly plays a role in the labour market and in the flow of remittances and goods between countries, but any assessment of its importance is hampered by lack of data. Refugees are another dimension of the problem.

A. Population size, structure and growth rates

6. Africa's total population, which was estimated at about 224 million in 1950, will reach 628.3 million in mid-1989 and 872.2 million by the turn of the century. Table 1 in the annex shows population distribution by subregion. In 1989, Eastern Africa will contain 30 per cent of Africa's total population, Middle Africa 10.7 per cent, North Africa 22.1 per cent, Southern Africa 6.4 per cent and West Africa 30.7 per cent.

13. Infant mortality which was estimated at 137 per 1,000 births in Africa between 1950-1955 has declined to the present figure of 106/1,000, representing a 43 per cent reduction. It is expected that by the turn of the century infant mortality will further decline to 88, as shown in table . Africa's present infant mortality rate is seven times that of more developed regions and 1.3 times that of less developed regions. Among the subregions in Africa, Southern Africa has the lowest rates of infant mortality followed by North Africa, Middle Africa and West Africa, while Eastern Africa has the highest rates.

14. A commonly used indicator to measure the impact of mortality and health conditions is life expectancy (i.e., the number of years a person could expect to live at birth under the prevailing health conditions, as shown in table 7. Between 1950-1955, life expectancy in Africa was 35.0 years. This estimate has increased by 38.6 per cent, to reach the present figure of 51.9 years and it is expected to reach 55.7 years between 1995-2000. Present life expectancy is 21.5 years lower in Africa than in the more developed countries.

D. Population distribution and internal migration

1. Urbanization

15. Of the total population in Africa, 22.5 per cent lived in urban areas in 1970; this increased to almost 30 per cent in 1985 and is expected to reach about 33 per cent in 1990, and 39 per cent by the year 2000. In contrast, about 72 per cent live in cities in more developed areas. The forecast of urban population in Africa by subregion in 1990 ranges from 21.5 per cent in Eastern Africa to 55.3 per cent in Southern Africa with 27.9 per cent in West Africa, 44.6 per cent in North Africa and 21.5 per cent in Middle Africa. Although Africa is the least urbanized region in the world, its urban population is growing at about 5 per cent per year; ranging from 6.0 per cent in Eastern Africa to 3.7 per cent in the North and Southern African subregions and 5.5 per cent for Middle and West Africa.

2. Internal migration and spatial population distribution

16. As most of Africa's population is in the rural areas, there is considerable movement of people within rural areas, but unfortunately no reliable data is available. The movement from rural to urban areas, however, causes more concern. In most countries the movement is concentrated usually in the capital cities or main commercial towns and the uneven distribution of the population is a serious problem for many governments. The reasons behind the rural to urban movement lie partly in the unequal development of both areas, although the varying distribution of the population in rural areas may be related to natural resource endowment, e.g., good agricultural land and the availability of water or to the prevalence of disease which may force people to move to safer places. Political factors may also contribute to uneven distribution of the population, for example the refugee problem which has affected and continues to affect many countries. Drought and desertification may cause population redistribution problems, as was stressed in APPER and the UN-PAAERD, which earmarked them priority areas for action.

E. Population-related policies

17. The population policies discussed here cover growth, fertility and family planning, population distribution and internal migration. The data refer to July 1986. It is worth stressing that, in spite of the pressing problems generated by the economic crisis that demand immediate action and, therefore, do not relate primarily to population issues, governments in the region increasingly turned their attention to population problems and began to draw up appropriate policies.

18. Thirty of the 51 African countries considered their population growth rates to be too high; 20 of them took steps to reduce the growth rates, but no direct intervention is reported from the other 10. Sixteen countries indicated their population growth to be satisfactory. Only five considered their rates as too low and two of them would like to raise the rates. Some of the countries have specific targets in view; for example, Nigeria, plans a reduction from the present 3.3 per cent per year to 2.6 per cent by the year 2000. Among the countries which have had growth rate reduction policies in force for some time, e.g., Kenya and Ghana, the results have not been successful, partly because the measures have not been vigorously applied and also because the mechanisms and infrastructures for implementation were weak. Furthermore, the cultural values favouring large families have not changed significantly in the majority of the population, so that it is almost impossible to implement a strong and effective policy. Lack of adequate resources was also a major constraint.

19. In 1986, three countries considered their fertility levels as too low and devised policies to increase them; 31 countries perceived their levels as too high and 21 of them took active steps to reduce the levels; 17 countries were satisfied with their levels. Direct support to the effective use of modern methods of fertility regulation was provided by 38 governments in 1986; in six others only indirect support was provided; and in only seven countries was no government support made available.

20. The change in perceptions to favour family planning programmes came in 1984 with the adoption of the Kilimanjaro Programme of Action, which called on governments to accept and implement family planning as part of the mother and child health programmes to lower infant, childhood and maternal mortality. Many countries now implement family planning for health reasons, in the context of primary health care programmes, while others also aim to reduce fertility and thus population growth rates. Such policies to reduce fertility have not yet been successful; fertility levels are still very high or increasing. Nigeria, for example, has set specific targets as recommended by the World Population Plan of Action with regard to reduction of fertility by the year 2000. These include the following:

(a) Family planning services should reach 80 per cent of the women of child-bearing age group;

(b) Total fertility to be reduced from the present level of more than six children per woman to about four children;

(c) To reduce by 80 per cent the proportion of women having children after age 35;

(d) Eighty per cent of the women of child-bearing age should receive their spacing interval of at least two years; and

(e) Reduce by 50 per cent the proportion of women marrying before the age of 18.

21. With regard to the spatial distribution of population in 1986, no country in Africa considered its geographical distribution as totally appropriate, 17 considered it as partially appropriate, while the majority (34) considered it as inappropriate.

22. Many governments are trying various ways to address these problems. In Ethiopia for example measures already put in place have been undertaken and are still being implemented. In Zambia the emphasis is on bringing isolated rural areas together through re-organization, village regrouping and the establishment of small-scale industries. In some countries, emphasis is on balanced development. Egypt is for instance siting new cities in desert areas and has designated several new growth development regions. In the rural areas, attempts are underway to create non-agricultural jobs. In some countries new capital cities have been established, partly in order to create a better distribution of population away from existing cities or regions. So far population distribution patterns do not seem to have achieved the desired effects.

III. IMPLEMENTATION OF POPULATION TRENDS IN IMPLEMENTATION OF THE UN-PAAERD

23. The UN-PAAERD called on ECA member states to accord special importance to the implementation of population policies in the context of the Kilimanjaro Programme of Action. Among the issues addressed in the PPA are those related to high fertility and mortality, rapid urbanization, rural-urban and rural-rural migration, problems relating to children and youth and the protection of the environment. The objective is to ensure compatibility between demographic trends, appropriate land utilization and settlement patterns and the desired pace of economic growth and development. The UN-PAAERD further called on ECA member States to push for the attainment of an agro-food production growth rate at least equal to the population growth rate within the shortest possible time. It has already been noted that the population policies implemented so far have not succeeded in many countries in reducing population growth rates. Population growth rates have surpassed economic growth rates. Some sectors are briefly referred to, using socio-economic indicators contained in an ECA study on "Beyond Recovery: ECA-revised perspectives of Africa's development 1986-2000".

24. While the overall performance of GDP during the first two years of the implementation of the UN-PAAERD increased by 1.2 and 1.5 per cent in real terms, in 1986 and 1987 respectively, the population growth rate in Africa for the same period was 3.0 per cent and per capita GDP growth rates were -2.0 per cent in 1986 and -1.7 per cent in 1987. The GDP growth rate in agriculture was 3 per cent in 1986 and fell to 1 per cent in 1987. With regard to GDP in investment, the growth rate was -5 per cent in both 1986 and 1987. Food production grew at between 1 and 1.5 per cent per year during the first half of the 1980s while population growth rate was about 3 per cent. The imbalance between food production and population growth rates

calls for the importation of great amounts of food which many African countries cannot afford because of their weak economies, debt payment problems and shortage of hard currency. A reject to food aid was necessary. Food shortages have had a considerable impact on nutrition and the health of the population, especially of the young, the mothers and the elderly, particularly in the case of refugees in some countries.

25. With regard to the problems related to children and youth, it should be noted that both these groups is growing very fast but increasing educational, health and employment needs are not being met as quickly. Investments in public and private education have declined since 1980. Government expenditure on education per capita dropped from $US 41 in 1980 to $US 28 in 1985. Enrolment increases in both primary and secondary schools declined between 1980 and 1985. There is no data available to show that the situation has improved. In higher education, enrolment increases dropped by 60 per cent between 1980 and the beginning of 1985. The quality of education has also deteriorated.

26. The situation related to employment opportunities is equally grim. An increasing number of primary and secondary school leavers have no chance of finding jobs, in many countries. University graduates find it difficult to get jobs. In 1985, 20 million people were unemployed and 95 million people were said to be underemployed. Between 1980 and 1986 income per capita declined at an annual rate of 3.4 per cent, while real wages during the same period declined by an average of at least 15 per cent. The overall impact of these trends on a rapidly growing population is increasing misery and a worsening of human conditions.

27. Population pressure is one of the causes of destruction of the natural ecosystems. Depletion of forests for fuelwood, overgrazing and poor land management all contribute to desertification, which in 1985 affected 27 African countries. The continued increase in population growth rates augments the demand for fuelwood to the extent that in some areas women have to walk long distances to fetch wood. The price has, therefore, increased several times over in most urban areas. Although afforestation programmes have been initiated in some countries, they are not on sufficient a scale to match the rate at which forests are destroyed. Moreover afforestation programmes will take a long time to have an impact on the destroyed environment. Nevertheless, the policies of afforestation and proper soil management should be vigorously implemented and alternative sources of energy should be explored. Women, whether in farming, fetching and collecting fuelwood or carrying water, are in constant touch with the environment and thus they should be more involved in programmes of environment management and protection.

28. Population growth pressures on urban development continue to frustrate government efforts to improve housing conditions, education, health, transportation, services, amenities and infrastructure. Unemployment has become a serious problem. Under such conditions, crime, juvenile delinquency and other social disorders tend to manifest themselves and even to become widespread.

29. Population is by no means the sole cause of Africa's socio-economic problems, but nevertheless it has a great impact. Continued population growth rates do, indeed, slow down most of the attempts to consolidate and broaden

broader socio-economic development. Hence any development strategies s include policies to influence population variables as put forward in KPA.

IV. SUMMARY AND ISSUES FOR DISCUSSION

30. The African population is estimated to have increased by 180 per to 628 million in 1989, since 1950 and half the people are under 17.3 Children and youth constitute respectively 45 and 19 per cent of the t Fertility has remained very high since the early 1950s at above six chi per woman. Mortality on the other hand, has declined considerably the 1950s; infant mortality declined by 43 per cent and crude death by 45 per cent. The present infant mortality rate for Africa, however seven times that of the more developed regions. Life expectancy at is 21 years behind the level of the more developed regions. The com effects of very high fertility and high but declining mortality have res in very high population growth rates; 3 per cent on average for Africa, many individual countries have even higher rates. Africa has the hi fertility, mortality and population growth rates, and the lowest expectancy at birth in comparison with all other regions of the world.

31. Africa is the least urbanized continent with only about a third of population living in urban areas. The urban population, however, is gr at about 5 per cent per year. This situation is expected to continue at least the turn of the century. Population distribution, in most count is considered as a serious problem and many attempts at solutions have so far been successful.

32. Perceptions on population issues have greatly changed among Af countries. The need to take population as a central variable in socio-eco development has been generally agreed upon. Family planning programmes now broadly accepted in protecting and improving the health of children mothers and sometimes for reducing fertility and population growth as well. Existing population policies to reduce fertility and popul growth rates have not been successful for many reasons - the progr were not vigorously implemented, the infrastructure and manage implementation were weak; the cultures and values favouring large fami did not change significantly; resources for the programmes were not adequat

33. Demographic factors during the period of the implementation of the PAAERD have had some impact in retarding the effect of efforts geare bring about a balance between the population dynamics and socio-econ development in general. No population programme, however vigoro implemented, could change population growth rates in as short a perio five years, but this does not mean that action should not be initiate pursued.

34. From the presentation above, the following issues may be put for for consideration, and discussion:

(a) Population dynamics will continue to affect socio-econ development adversely, if present trends in both population and econ growth are not matched. It is not enough merely to include populatio a central factor of socio-economic development; more countries need to formulate and implement relevant comprehensive population policies to complement socio-economic development;

(b) Based on past experiences of various population-related policies, alternative solutions should continually be sought;

(c) Any policies designed to reduce fertility and population growth rates must ensure: (i) that the population at grass roots (both men and women) are motivated through population information education on the advantages of small family size; (ii) that traditional values favouring birth spacing be reinstated and that smaller families should be preferred; (iii) that family planning programmes and the means of regulating fertility should be made available to the majority of the population, especially in the rural areas; (iv) that local communities are involved in the programmes; (v) that, where necessary, legislation be taken or amended to facilitate the increased use of modern methods on fertility regulations; and (vi) that action to decrease infant and child mortality be stepped up, as the survival of children is seen as an insurance for the future of the parents;

(d) Mechanisms and institutions for designing and monitoring policies should be put into effect;

(e) Women should be actively involved in the formulation and implementation of policies which affect their lives. Policies relating to population and women in the development process should be promoted and implemented; and

(f) Governments which have not yet initiated explicit population policies should do so, in line with the recommendations of the KPA.

35. Population is a resource which could be put to good use to solve the existing socio-economic problems besetting Africa. The challenge remains of how best the existing large human numbers can be used to solve the problems of development. Past and present actions have failed, and there may be little hope that with larger populations a better future lies ahead. Population is both an asset and a liability, but obviously with less pressure on the demand and with more opportunity to use its human resources to the best advantage, Africa should benefit greatly.

Table 1: African population 1950-2000
(in thousands)

Region	1950	1989	1990	1995	2000
Eastern Africa	64 978	188 765	194 823	228 947	269 185
Middle Africa	26 841	67 543	69 564	80 710	93 498
Northern Africa	51 798	138 908	142 645	161 832	181 481
Southern Africa	15 736	40 037	40 972	45 889	51 172
Western Africa	64 722	193 064	199 511	235 247	276 898
All Africa	224 075	628 317	647 518	752 626	872 234

Source: United Nations, World Population Prospects, 1988 Assessment, Medium Variant (computer printouts).

Table 2: Annual population growth rates in Africa in comparison with more developed and less developed regions, 1950-2000
(in percentage)

Region	1950-1955	1975-1980	1985-1990	1995-2000
Eastern Africa	2.26	3.04	3.09	3.24
Middle Africa	1.85	3.01	2.91	2.94
Northern Africa	2.26	2.78	2.73	2.29
Southern Africa	2.28	2.31	2.33	2.18
Western Africa	2.13	3.10	3.26	3.26
Total Africa	2.18	2.85	3.00	2.95
World	1.80	1.74	1.73	1.62
More developed regions	1.28	0.73	0.53	0.45
Less developed regions	2.05	2.10	2.10	1.92

Source: United Nations, World Population Prospects, 1988 Assessment, Medium variant (computer printouts).

Table 3: Crude birth rates in Africa in comparison with more developed and less developed regions 1950-2000
(per 1,000 population)

Region	1950-1955	1985-1990	1995-2000
Eastern Africa	50.3	47.8	45.9
Middle Africa	46.6	44.9	42.5
Northern Africa	48.9	38.0	30.9
Southern Africa	43.7	33.4	29.8
Western AFrica	49.7	48.9	46.0
Total Africa	48.9	44.7	41.4
World	37.4	27.1	24.8
More developed regions	22.6	14.6	13.5
Less developed regions	44.6	30.9	27.7

Source: United Nations, World Population Prospects, 1988 Assessment, medium variant (computer printouts).

Table 4: Total fertility rate in Africa in comparison with more developed and less developed regions 1950-2000

Region	1950-1955	1985-1990	1995-2000
Eastern Africa	6.71	6.74	6.36
Middle Africa	5.92	6.03	5.72
Northern Africa	6.83	5.32	4.17
Southern Africa	6.45	4.68	4.10
Western Africa	6.69	6.84	6.38
Total Africa	6.61	6.23	5.66
World	5.00	3.44	3.13
More developed regions	2.84	1.90	1.90
Less developed regions	6.18	3.92	3.45

Source: United Nations, World Population Prospects, 1988 Assessment, medium variant (computer printouts).

Table 5: Crude death rates in Africa in comparison with more developed and less developing regions, 1950-2000
(per 1,000 population)

Region	1950-1955	1985-1990	1995-2000
Eastern Africa	28.2	17.0	13.5
Middle Africa	27.6	16.0	13.2
Northern Africa	24.7	10.7	8.0
Southern Africa	21.0	10.1	8.0
Western Africa	28.5	16.5	13.5
Total Africa	27.0	14.9	12.0
World	19.7	9.9	8.7
More developed regions	10.1	9.8	9.5
Less developed regions	24.3	9.9	8.5

Source: United Nations, World Population Prospects, 1988 Assessment, medium variant (computer printouts).

Table 6: Infant mortality rate per 1,000 births in Africa in comparison with more developed and less developed regions, 1950-2000

Region	1950-1955	1985-1990	1995-2000
Eastern Africa	179	116	97
Middle Africa	183	107	89
Northern Africa	189	86	63
Southern Africa	152	77	57
Western Africa	204	112	94
Total Africa	187	106	88
World	155	71	58
More developed regions	56	15	11
Less developed regions	180	79	64

Source: United Nations, World Population Prospects, 1988 Assessment, medium variant (computer printouts).

Table 7. Life expectancy at birth in Africa in comparison with more developed and less developed regions, 1950-2000
(in years for both sexes)

Region	1950-1955	1985-1990	1995-2000
Eastern Africa	36.5	49.8	54.0
Middle Africa	36.9	50.0	54.0
Northern Africa	41.9	59.0	63.1
Southern Africa	44.1	59.7	64.5
Western Africa	35.6	49.4	53.5
Total Africa	38.0	51.9	55.7
World	45.9	61.5	64.5
More developed regions	65.7	73.4	75.4
Less developed regions	41.0	59.7	63.1

Source: United Nations, World Population Prospects, 1988 Assessment, medium variant (computer printouts).

E/ECA/CM.13/20

I. INTRODUCTION

1. During the period 1988-1989, the ECA work programme has been influenced particularly by two important prerequisites:

(a) To base all the activities of the Commission on the United Nations Programme of Action for African Economic Recovery and Development (UN-PAAERD), which was adopted in June 1986 by the thirteenth special session of the General Assembly of the United Nations;

(b) To give preference to operational activities because of their specific nature and tangible impact on development.

This new direction explains why of the total of $US 84,176,633 allocated to the Commission for 1988-1989, the sum of $US 44,023,000, from the regular budget was devoted to the usual activities of the ECA secretariat, particularly general macro-economic studies, the organization of sectoral meetings and production of reports on these meetings and technical publications. The remaining $US 40,153,633 from the overall budget was almost entirely devoted to operational activities, notably to advisory services to member States, to the supply of modern facilities for public departments or technical institutions in different countries, the organization of seminars, training workshops and study tours aimed at giving African experts the opportunity of having meaningful contacts and of increasing their relative skills in their individual fields.

2. The graph below shows the resource flows assigned to ECA between 1984 and 1989 according to sources: United Nations regular budget or extrabudgetary resources.

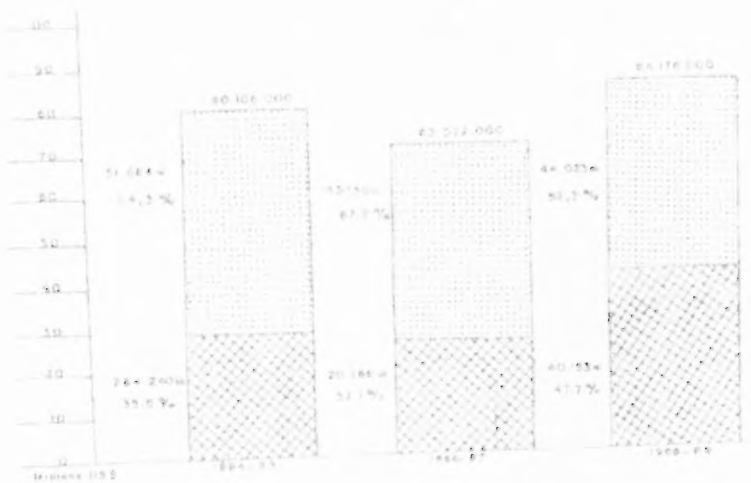


Fig. 1

[ ] Resource flows from 1984-1989 [ ]
(in millions of $US)

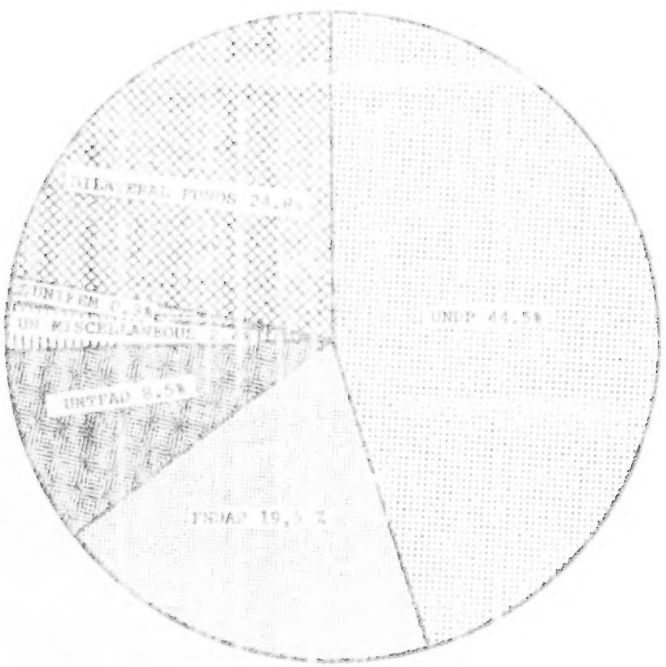
3. The flow of financial resources shown in the graph above may be explained in the following terms:

(a) The 20 per cent drop in overall resources during 1986-1987, in comparison with 1984-1985, was caused by the international financial crisis affecting all Member States of the United Nations. Nevertheless, it may be seen that the share of extrabudgetary resources during 1986-1987 (33 per cent) was greater than that in 1984-1985. This trend was due to the fact that member States opted to emphasize technical co-operation activities and bilateral assistance;

(b) During 1988-1989 it should be noted that the United Nations financial crisis continued to affect the regular budget, which explains why the level remained approximately the same (US$ 43,156,000 in 1986-1987 compared with $US 44,023,000 in 1988-1989). While the share of extrabudgetary resources rose to 47 per cent, in comparison with 32 per cent in 1986-1987. This analysis of the resource curve bears out the preference of countries for bilateral assistance and operational activities;

II. EXTRABUDGETARY RESOURCES AND OPERATIONAL ACTIVITIES

4. During 1988-1989, extrabudgetary resources of ECA were provided by the three usual sources: United Nations specialized agencies ($US 26,768,363), countries or international institutions which had bilateral technical co-operation agreements with ECA ($US 9,959,276), the United Nations Trust Fund for African Development (UNTFAD) ($US 3,425,394).



A. Support from the United Nations system

5. This is made up of (in $US):

(1)	United Nations Development Programme (UNDP)	$US 17,866,392
(2)	United Nations Population Fund (UNFPA)	7,808,508
(3)	United Nations Development Fund for Women (UNIFEM)	123,023
(4)	Miscellaneous	970,440
	Total	26,768,363

1. UNDP support

6. The diagram above shows that UNDP is ECA's main partner for funding the operational activities of the Commission. This situation arises from the fact that because resolution 32/197 of the United Nations General Assembly established ECA as the only body within the United Nations system to deal with all development projects and programmes of a multisectoral and multinational nature concerning Africa, ECA was the obvious choice to be designated the executing agency for subregional and regional multisectoral projects financed by UNDP. Thus, UNDP agreed to finance the following projects submitted by the ECA secretariat, under the regional IPF for the fourth programming cycle.

	Title	Budget 1988-1989
1.	Trypanosomiasis control in the Kagera Basin	397,000
2.	Assistance to the African Institute for Economic Development and Planning (IDEP)	1,729,950
3.	Assistance to African States on their structural adjustment programmes	550,000
4.	Assistance in the development of building materials in Africa	264,167
5.	Assistance to the African Regional Centre for Engineering Design and Manufacturing (ARCEDEM: phase II)	249,000
6.	Assistance to PADIS	1,584,564
7.	Assistance in personnel training in the state trading organizations	390,000

		Budget 1988-1989
8.	Assistance to the Regional Centre for Services in Surveying, Mapping and Remote Sensing	30,000
9.	Assistance to the African Regional Organization for Standardization (ARSO)	691,934
10.	Assistance to the Regional Centre for Training in Aerial Surveys	94,367
11.	Assistance to the African Regional Centre for Technology (ARCT)	2,091,200
12.	Preparatory assistance in the development of a remote sensing programme in Africa	21,946
13.	Organization of high-level seminars	333,935
14.	Assistance to the Eastern and Southern African Management Institute (ESAMI)	107,866
15.	Preparatory assistance for the African Institute of Higher Technical Training and Research	287,215
16.	Assistance to LDCs and NICs	3,550
17.	Statistical Development Programme for Africa	1,540,014
18.	Household Survey in Cape Verde	117,174
19.	Co-ordination of the implementation of the United Nations Transport and Communications Decade in Africa	882,462
20.	Strengthening the Co-ordination unit of the United Nations Transport and Communications Decade in Africa	222,384
21.	Study on gas pipelines in Africa	528,500
22.	Study on railways in Namibia	36,872
23.	Improving African women's role in the informal sector	1,230,265
24.	Assistance on advisory services to African States	450,201
25.	Support for the activities of the CEPGL	1,798,989
26.	Support for Niamey MULPOC activities	175,000
26.	Strengthening the capabilities of African universities	594,300
28.	Strengthening the Documentation Centre in the Kagera Basin Organization	215,200

Budget 19

29. Assistance to the Economic Community of Central African States (ECCAS)

30. Reinforcement of the management of human resources in the transport sector

31. Support for the activities of ARCEDEM: phase III

17.

7. On UNDP financing, it should be noted that with the exception project "PADIS-North Africa", all the projects listed above are finance the African Regional IPF administered by the Regional Bureau for Africa (

8. The relationship between ECA and this organ of UNDP has been parti good throughout the 1988-1989 because, not only have the 31 projects above been approved but, equally, assurances have been given to EC favourable examination of the following projects currently under consider

1. The Rusumo Falls power transmission line project (KBO)

2. The establishment of the African Centre for the Prevention of Cr the Treatment of Offenders (UNAFRI)

3. The Promotion of African building materials

4. Promotion of transport and communications equipment in Africa

5. Assistance on debt management in Africa

6. Assistance to the Lusaka MULPOC

7. Reinforcement of the operational capacity of the ECA secretar the implementation of the UN-PAAERD

8. The advancement of African women in science and technology

9. The strengthening of national administrative capacities to as economic recovery

10. Assistance to the Economic Community of the Great Lakes Countries in the execution of multisectoral projects

11. Assistance to the Economic Community of West African States in the execution of multisectoral projects

12. Assistance to the Central African Customs and Economic Union in the execution of multisectoral projects

13. Assistance to the African Institute for Economic Development and (IDEP) for the period 1990-1991.

9. In addition, joint meetings were organized by UNDP's Regional Bureau for Africa and ECA to harmonize their attitudes and respective actions on the pressing problems of Africa, such as the African debt problem, structural adjustment programmes, the implementation of the UN-PAAERD, etc. Without any doubt this pooling of efforts will allow both bodies to assist African States in their tasks of development and social and economic integration in a more efficient and less costly manner.

10. The relationships between ECA and the Regional Bureau for Arab States and European Programmes (RBASEP), which includes eight African States among the 29 countries within its jurisdiction, have not been as fruitful in 1988-1989 as ECA would have hoped. In fact, of the five projects which were submitted by ECA, only one was approved: that on PADIS-North Africa. The other projects submitted were:

1. The establishment of a Preferential Trade Area for North Africa;

2. Support for the activities of the African Regional Organization for Standardization (ARSO);

3. The integration of women into the development process in North Africa;

4. Assistance on the development of statistical activities in North Africa.

11. It is to be hoped that not only will the other projects be accepted in the near future, but also that greater contact will be established and measures co-ordinated for the integrated development of the member States of ECA covered by UNDP's Regional Bureau for Arab States and European Programmes.

2. UNFPA

12. UNFPA's support is devoted entirely to advisory services and technical assistance to ECA member States and to the institutions serving them, particularly in the collection and processing of statistical data, population census activities, the training and upgrading of statisticians and demographers and the dissemination of technical information on statistics and demography, etc.

3. UNIFEM

13. The $US 123,000 of support from UNIFEM were used to carry out two projects in the 1988-1989 period:

(a) Seminars on project formulation for Portuguese-speaking countries;

(b) Assistance to the Ethiopian Institute of Nutrition.

4. Other support from the United Nations system

14. Other support from the United Nations system is to cover the costs of project activities undertaken by ECA as the executing agency of the project concerned. In this category belong the following ECA-executed projects:

(a) RAF/88/034/B/01/37: Joint UNIDO-ECA activities in the context of the Industrial Development Decade for Africa;

(b) RAF/86/058 (IBRD-ECA) - Data collection related to development programmes and aid flows in to Africa;

(c) Joint ECA-DTCD activities on river and lake basin development.

B. Bilateral support

15. As discussed earlier, these ECA resources derive from specific co-operation agreements, by which donor States (usually industrialized) or international institutions designate to the secretariat of the Commission the execution of multisectoral and multinational projects, whose objectives conform both with the donor States' programmes of assistance and with the specific work programme of the Commission. Bilateral assistance usually takes one of three forms:

(a) The direct financing of specific projects;

(b) The secondment of the services of national experts to ECA;

(c) The granting of fellowships and other material means of training and technical assistance to donor countries.

16. During 1988-1989, the sum total of ECA bilateral co-operation was:

(a) The Federal Republic of Germany: an allocation of $US 1,453,261 for:

(i) Financing of two projects:

- Enhancing food security;

- Seminars on the organization of rural telecommunications networks in French-speaking countries of Africa;

(ii) The provision of the services of bilateral experts specialized in mineral resources (particularly coal and lignite), post-harvest losses, the processing of statistical data and telecommunications, particularly the co-ordination of networks.

(b) Belgium: A total of $US 709,778 was allocated to financing the following projects:

(i) The reduction of food losses by the control of insect parasites;

(ii) An inventory and evaluation of African mineral resources for industrial use.

(c) Canada: Co-operation with ECA was effected through:

(i) The International Development Research Centre (IDRC) which allocated a total sum of $US 504,780 to finance the execution of the following projects:

- Assistance to the operational use [illegible] of PADIS (DEVSIS: Phase III).

- Assistance to POPIN Africa on information on population activities in Africa.

- The advancement of women in science and technology.

(ii) The Canadian International Development Agency (CIDA) which granted $US 125,020 for women's [illegible] activities in the Economic Community of the Great Lakes Countries (Burundi, Rwanda and Zaire).

(d) China: $US [illegible],720 was [illegible] directly to ECA for the purpose of organizing a study tour to China on desertification and the environment.

(e) France: A [illegible] total of $US 416,000 was allocated to provide for the secondment of two national specialists in fishery and sea bed resources.

(f) India: Contributed a total of $US 482,158 to assist ECA execute projects on:

(i) The promotion of small industries particularly in rural areas;

(ii) The management of materials and equipment in Africa;

(iii) The development of industrial engineering in Africa.

(g) Japan: Direct co-operation between ECA and Japan has only just been established with the $US [illegible] allocated to ECA in order to invite eight member States and the Executive Secretary to participate in a symposium on the planning of rural development.

(h) The Netherlands: ECA has always maintained very fruitful co-operation with this country. During 1988-1989, the total granted to ECA was $US 514,617 to finance the execution of projects on:

(i) Applied research on the development of maize production;

(ii) The preparation and promotion of composite flours;

(iii) The training of women on establishing and developing private enterprises;

(iv) Strengthening the capacities of ECA in the identification, preparation and evaluation of development projects.

(i) Sweden: The Swedish International Development Agency (SIDA) granted $US 386,985 for the execution of a project promoting the access of women to financial credit.

(j) Italy: The agreement concluded between ECA and this country concerns the technical assistance that Italy will give (set at $US 4,520,000) to the preparation of a master plan on African road networks.

(k) USSR: The Soviet Government approved a total allocation of $US 941,900 for the period 1986-1989 for the organization in the USSR of the following activities:

(i) A seminar on port organization and management;

(ii) A seminar on information systems;

(iii) A workshop on the management and development of human resources;

(iv) A seminar on spending programmes;

(v) A seminar on tourism;

(vi) A seminar on marine resources;

(vii) A seminar on urban development;

(viii) A seminar on the engineering and manufacture of industrial models.

(l) The Ford Foundation: This American agency gave ECA $US 146,000 for research into women's activities in the informal sector and in agro-industry.

(m) The Intergovernmental Committee on Migration: This institution gave $US 75,094 to ECA to help in its efforts to retain and recall African brain power.

(n) USAID: This American agency made $US 87,125 available to ECA for manpower training activities.

17. The above shows that total bilateral resources mobilized by ECA in 1988-1989 amounted to $US 9,459,276, which was 24 per cent of the overall volume of extrabudgetary resources for the period.

C. Activities financed by UNTFAD

18. Since the creation of this Fund in 1976, six donor conferences have been organized, during which contributions of $US 11,482,001 were promised. These promises materialized to the extent of payments of $US 9,057,799. Over the years, funds have been on UNTFAD resources to finance ECA activities. Periodic reports on the use of these resources have been presented to previous ECA Conferences of Ministers.

19. During 1988-1989, UNTFAD contributed a total of $US 3,425,994 to finance operational activities in the Commission's work programme. It should be pointed out that the secretariat has placed special attention on the use of UNTFAD funds during the period, because of the international financial crisis which has particularly affected African economies and the (now very limited) financial resources that they can devote towards communal development activities. Bearing in mind these considerations, the Project Analysis Committee, recently created

and presided over by the Executive Secretary personally, examined and decided in favour of UNTFAD finance for all or part of the costs of the following projects:

(a) Study on the production of food crops by women in West Africa - $US 10,000 has been released for the implementation of this study;

(b) Study tour and regional workshop on increasing the income of small-scale livestock breeders: $US 30,000 has been devoted to this project;

(c) $US 130,000 has been assigned to defray the costs of the PADIS operations not yet financed from other sources;

(d) An information bulletin on water resources development in Africa $US 11,496 is budgeted to prepare and disseminate this bulletin;

(e) A total sum of $US 55,698 was devoted to specific activities for the advancement of women in the CEPGL countries (Burundi, Rwanda, Zaire);

(f) Various MULPOC activities were supported as follows: Lusaka MULPOC: $US 130,000; Niamey MULPOC: $US 37,855; Yaoundé MULPOC: $US 255,255; Gisenyi MULPOC: $US 275,000;

(g) $US 350,000 was set aside to support a programme to promote capital goods industries in African States;

(h) Similarly, the sum of $US 401,602 was allocated to finance projects for the promotion of small-scale industry in Africa;

(i) $US 213,349 was set aside from UNTFAD funds for the conception and implementation of a programme and projects for chemical industries.

20. On the current situation of the UNTFAD account, at the close of business on 31 December 1980, the ECA financial statement showed a credit balance of $US 2,227,621. This overall figure included funds for general and specific purposes, capital and accumulated interest, disbursements already made and commitments.

21. The account books of ECA, however, show that the countries and others listed below have not paid their respective promised contributions (expressed in US dollars): Benin: 10,000; Botswana: 5,000; Burundi: 21,912; Cameroon: 156,000; Central African Republic (CAR): 8,125; Congo: 26,825; Chad: 20,000; Gabon: 21,052; Guinea: 1,000; Guinea-Bissau: 926; Kenya: 137,005; Liberia: 40,000; Libyan Arab Jamahiriya: 100,000; Mali: 45,654; Morocco: 800,000; Niger: 26,529; Nigeria: 315,148; Rwanda: 15,000; Senegal: 6,000; Sierra Leone: 42,625; Tanzania: 314,604; Togo: 650; Zaire: 53,000; Zimbabwe: 29,836; India: 200,101; Cyprus: 1,000; ECA Staff Association: 25,100. This adds up to a total of $US 2,424,202 of undertakings unpaid, which the States concerned are urged to honour as soon as possible.

22. Furthermore, all the member States of ECA as well as the entire international community are urged to take part in the seventh Pledging Conference, to be held in Addis Ababa on April 1989 and (in conformity with resolution 37/139 of the General Assembly of the United Nations) to contribute generously to UNTFAD in order to help ECA implement its 1990-1991 work programme. The documents specifically relevant to the 8 April 1989 meeting have been prepared by the ECA secretariat for distribution to participants at the fifteenth meeting of the ECA Conference of Ministers.

III. CONCLUSION

23. It follows from the report presented above, that in line with the changes in the concerns of member States and the aid policies of its partners in the international community, ECA in 1988-1989 continued to focus on operational activities, by increasingly concentrating on the implementation of multinational and multisectoral projects, with immediately attainable objectives and tangible results. In order to do this, ECA succeeded in mobilizing additional extrabudgetary resources and in implementing more projects than in the preceding years. ECA is also counted among the major UNDP executing agencies. Without doubt, these positive factors result from the fact that ECA, as the organization designated by the United Nations to analyze and consider all questions on African development was the obvious choice to be the major focus for the implementation of the recovery programmes detailed in the context of the development crisis in the African continent. The resources put voluntarily at its disposal by member States and by the international community have certainly been greater in 1988-1989, but those deemed necessary to carry out its operational activities in 1990-1991 will be even greater and deserve the support of all financial sources. As a result, therefore, a separate report on the extrabudgetary resource needs for 1990-1991 has been prepared and made available to participants in the fifteenth meeting of the Conference of Ministers.

A. ATTENDANCE AND ORGANIZATION OF WORK

1. Pursuant to the Economic Commission for Africa's Conference of Ministers resolution 541 (XX) of 29 April 1985 which formally established the Conference of African Ministers of Finance to deal with all issues relating to money and finance, the third session of the Conference of African Ministers of Finance was held in Blantyre, Malawi, from 6 to 8 March 1989. Previously, the Conference of African Ministers of Finance had met in Libreville in June 1986 to consider the establishment of the African Monetary Fund. The purpose of the Conference was threefold: to critically examine the premises of orthodox structural adjustment programmes and to consider a comprehensive alternative to such programmes; to consider the question of domestic and external resources management as well as external debt management; and to review the important issue of the establishment of an African Monetary Fund that would enable African countries to respond more effectively to adverse developments in international matters and financial relations.

2. The meeting of the Conference of African Ministers of Finance was attended by representatives of the following member States: Algeria, Burkina Faso, Burundi, Cameroon, the Central African Republic, the Congo, Djibouti, Egypt, Ethiopia, Guinea, Gabon, the Gambia, Lesotho, Malawi, Mali, Mauritania, Morocco, Nigeria, Rwanda, Senegal, Somalia, Togo, Uganda, the United Republic of Tanzania, Zaire, Zambia and Zimbabwe.

3. Representatives of the following institutions attended the meeting as observers the International Monetary Fund (IMF), the Organization of African Unity (OAU) and the African Development Bank (ADB).

B. OPENING OF THE MEETING

4. On behalf of the outgoing bureau, the Minister of Finance of Zambia, Honourable Gibson Chigaga, welcomed the participants to the third meeting of the Conference of African Ministers of Finance and expressed profound gratitude to His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda, the Government and people of Malawi for their generous hospitality, and the excellent facilities for the Conference. The meeting had the very important task of assessing conventional structural adjustment programmes and coming up with alternative approaches.

5. In his statement, Professor Adebayo Adedeji, United Nations Under-Secretary-General and Executive Secretary of the Economic Commission for Africa, expressed appreciation to His Excellency the Life President of the Republic of Malawi, Ngwazi Dr. H. Kamuzu Banda, the Government and people of Malawi for hosting the Conference and for the warm welcome and hospitality extended to participants. The conference was historic in two ways. This

was the first time Africa was collectively undertaking a critical examination of the premises of conventional structural adjustment programmes (SAPs). It was also the first time that the region was attempting to come up with a coherent and comprehensive alternative that would lay new foundations for major reorientations of policy in the 1990s, in conformity with the tenets of the Lagos Plan of Action (LPA), Africa's Priority Programme for Economic Recovery, 1986-1990 (APPER) and the United Nations Programme of Action for African Economic Recovery and Development (UN-PAAERD).

6. He outlined the reasons behind the efforts of ECA to undertake a major study aimed at critically examining the existing stabilization and structural adjustment programmes in Africa and at searching for the viable and effective alternative. As a result of this, ECA had come up with a proposed African Alternative for Structural Adjustment Programmes (AA-SAP). This alternative focused on the fundamental issues of human-centred self-sustaining development, greater democratization of the development process, greater accountability of policy-makers and public officials and acceleration of economic co-operation and integration. It also proposed new policy instruments and measures as well as implementation strategies.

7. The question was not whether to adjust or not but rather how to adjust and what structures to adjust. He drew the attention of the Conference to two other agenda items relating to domestic and external resources management, including external debt, and the establishment of an African Monetary Fund. The issues involved had to be considered in the context of the required changes in policy directions, instruments and measures for adjustment with transformation. He called on the international community to support AA-SAP, by showing a greater understanding of the nature of Africa's development problems and by providing greater financial assistance to sustain Africa's own policy reforms.

8. In his opening statement, the Honourable Minister of Trade, Industry and Tourism, Mr. Robson W. Chirwa, MP, welcomed the Ministers of Finance to Malawi on behalf of His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda, President of the Republic of Malawi, and expressed his gratitude to the Life President for appointing him to officially open the meeting on his behalf.

9. Since the early 1980s, a number of countries had embarked on structural adjustment programmes supported by the IMF, World Bank and other donors in order to address their socio-economic problems and enable them to achieve some recovery and sustained economic growth. However, after almost a decade of such programmes, the economies had not attained any real growth and financial equilibrium. Instead, the programmes had aggravated the hardships, particularly to the poor. Malawi had since 1981 implemented a series of structural

adjustment programmes with modest success. The lessons from experience were as follows: there was always a need for countries to constantly adjust to the changing international economic environment; Governments had to be fully committed to structural adjustment programmes; and, structural adjustment programmes should be seen as a learning process for everybody involved, including the international financial institutions.

10. Finally, he urged the Conference to adopt a realistic and pragmatic African approach to adjustment so as to identify the root causes of the continuing social and economic difficulties facing Africans and to suggest policy direction and measures that would lead to transformation with sustained growth and increased welfare for the people of Africa.

Election of officers (agenda item 2)

11. The Conference elected the following officers:

Chairman:	Malawi
First Vice-Chairman:	Morocco
Second Vice-Chairman:	Ethiopia
Third Vice-Chairman:	Central African Republic
Rapporteur:	Senegal

C. AGENDA

Adoption of the agenda and programme of work (agenda item 3)

12. The Conference adopted the following agenda:

1. Opening ceremony.

2. Election of officers.

3. Adoption of the agenda and programme of work.

4. Consideration of the report of experts on:

   (a) An African Alternative for Structural Adjustment Programmes: A Framework for Transformation and Recovery;

   (b) Alternative systems of external resources management, including external debt; and

   (c) Progress towards the establishment of an African Monetary Fund.

5. Date and venue of the fourth meeting of the Conference of African Ministers of Finance.

6. Any other business.

7. Adoption of the report and closure of the meeting.

D. ACCOUNT OF PROCEEDINGS

Consideration of the Report of Experts (agenda item 4)

13. The report of the meeting of the Intergovernmental Group of Experts on the African Framework for Structural Adjustment Programmes was introduced by the Chairman of the meeting. The meeting had reviewed the proposal for an African Alternative to Structural Adjustment Programmes; alternative systems of external resources management including external debts; and progress towards the establishment of an African Monetary Fund.

14. The meeting of the Intergovernmental Group of Experts had unanimously expressed appreciation for ECA's initiative and noted that (a) some African countries were already implementing some of the policy recommendations; (b) the performance of countries which had adopted structural adjustment programmes needed to be compared with that of those which had not; (c) there were likely to be some difficulties in trying to attain the objectives of the proposal especially as far as availability of resources was concerned; (d) the inclusion of "social action programmes" in conventional SAPs could improve them; (e) difficulties might arise with respect to the implementability, acceptability and fundability of the African alternative. The meeting had also sounded a note of warning with respect to limiting debt-servicing ratios to a fixed percentage of export earnings.

15. The discussions on the alternative systems of external resources management had focused on the issues of improving resource flows to Africa and enhancing the domestic mobilization of resources for economic development. On the issue of the establishment of an African Monetary Fund, the position of the meeting of the intergovernmental Group was that the decision to give the mandate to the Governors of African Central Banks to pursue the matter had to be left to the Ministers who, in the first instance, had established the Libreville Ministerial Ad Hoc Committee.

16. The Ministers expressed their sincere appreciation to the Life President of the Republic of Malawi, H.E. Ngwazi Dr. H. Kamuzu Banda, the Government and people of Malawi for the warm hospitality and excellent facilities that had been provided for the Conference.

17. The Ministers concluded that the document required further refinements supported by appropriate empirical research and they also noted that some of the proposals were already being implemented in some form or other in a number of African countries. Nonetheless, the proposals as a whole constituted an important departure from the conventional programmes and provided a useful

framework for bringing Africa's adjustment efforts in line with the mapped out in Africa's programmes such as the LPA, APPER and the UN-P they also provided a valuable basis for the design of national prog and for negotiations with international financial institutions.

18. The Ministers also made useful comments and recommendations on sp policy instruments proposed in the document with particular reference to 5.1 and 5.2 and recommended that proposals in areas such as multiple ex rates, subsidies, import controls, interest differentials, price co and the informal sector needed more research and scrutiny.

19. Many African countries had undertaken SAPs due largely to fir difficulties and the need to obtain balance-of-payments support and addi inflows of foreign exchange. The African alternative framework had the to take cognizance of the need to guarantee continuous inflows of f exchange resources in the course of adjustment. The amount of res required to sustain the process of adjustment was one of the main diffe between AA-SAP and S.F. Compared to the shortterm orientation and time-p of SAP, the adjustment with transformation goal of AA-SAP might requir financing and funding.

20. It was felt that a lot more work might have to be done to mak framework generally acceptable and credible to the multilateral fir and development institutions and other donors. It was noted, however, the crucial issue was for Africa to first assure itself that it had a fe and workable alternative framework and to resolve to use that framewo design its new generation of adjustment programmes and carry out negoti to secure assistance from its development partners. AA-SAP could p a new basis for Africa in its dealings and negotiations with its devel partners; it should not be a basis for confrontation or antagonism. of the policy directions and policy measures in AA-SAP, it was felt, ha designed to make development assistance and development programmes effective and should, therefore, be recommended to all those interest Africa's recovery and development, including both the IMF and the World Ba

21. The Ministers stressed the need to harmonize SAPs, recalled the impo of subregional and regional integration as an important step toward harmonization of structural adjustment programmes for African countries this regard, they stressed the need for holding more regular consult on issues relating to structural adjustment programmes as well as other mor and financial issues.

22. As a follow-up to the meeting of the Ministers of Finance, ECA s revise the document on AA-SAP to reflect the observations and commen the report of the Conference. There should be a joint meeting of the Mini of Finance and Planning to further deliberate on AA-SAP and approv

Thereafter, efforts must be made to inform the IMF, the World Bank, the African Group in New York and the international community at large about the contents and basic directions of AA-SAP and to ensure that the framework was translated into concrete programmes at the country level.

23. In reaction to the discussions and deliberations, the ECA Executive Secretary once again stated that the present document on AA-SAP was only the beginning of an evolving process, one innovative aspect of which was the addition of a regional dimension to adjustment. AA-SAP was not a programme of adjustment in itself. It was a framework for African countries to use as a basis for designing and holding negotiations on adjustment programmes. Measures such as multiple exchange rates, differential interest rates and subsidies, had to be used with caution. It did not necessarily mean that they could not be used at all or had not been successfully applied. Concerning the follow-up process, he confirmed that the Conference of African Ministers of Planning would take place in Addis Ababa from 6 April 1989 at which the revised version of the document on AA-SAP would be discussed. Thereafter, a joint meeting of African Ministers of Finance and Planning could be held on 10 April 1989 for joint adoption of the document. The document would then be channelled to the Development Committee through the Joint Meeting of African Governors of the IMF and the World Bank and to the Economic and Social Council as well as the Inter-agency Task Force on UN-PAERD.

24. At the end of its deliberations, the Conference unanimously adopted "The Blantyre Statement of African Ministers of Finance on the Alternative Framework for Structural Adjustment Programmes". This is attached as annex I.

Alternative systems of external resources management, including external debt [agenda item 4 (b)]

25. On this agenda item the OAU representative briefed the Conference on the work of the Contact Group on Africa's External Debt Crisis which had been established in March 1988. Between March and May 1988, members of the Group had carried out a number of missions to developed countries to which African countries were indebted to seek support for the proposed International Conference on Africa's External Indebtedness.

26. The authorities contacted had indicated that they preferred the debt problems of African countries to be discussed at meetings of the London and Paris Clubs. They had also raised questions on the analysis and presentations in the African Common Position paper on external debt. He also briefed the Conference on th international seminar on the African Common Position on Africa's External Debt Crisis, scheduled to be held in Cairo, Egypt, from 28 to 30 August 1989. He urged all member States to send representatives to the seminar which was part of the preparatory process for the proposed International Conference on Africa's External Indebtedness.

27. The Conference drew attention to the proposals in the background paper on policy measures for resource mobilization and underscored the necessity to formulate taxation policies which were compatible with the promotion of production. It also emphasized the need to enhance the mobilization of private savings, which would in turn promote private investment. The Conference took note of the policy measures recommended on enhancement of mobilization of resources both for the public and private sectors.

Progress towards the establishment of an African Monetary Fund (agenda item 4 (c))

28. In view of the difficulties in convening a meeting of the Libreville Committee which had in 1986 been assigned the responsibility of examining the modalities for speeding up the establishment of the African Monetary Fund, the Conference was requested to provide guidance on how the secretariat should now proceed in its endeavour to promote the establishment of the Fund. Three proposals were made by the secretariat, namely (a) dissolving the Committee of Libreville and transferring its responsibilities to African central bank governors; (b) dissolving the Committee and establishing a new one; and (c) increasing the membership of the Committee.

29. In the discussions that followed, it was observed that decision by the Heads of State and Government of the OAU to establish an African monetary Fund was final. Concern was therefore expressed on the reported opposition to the establishment of the Fund which had caused a long delay in its establishment. The representative of the African Development Bank (ADB) indicated that opposition to the establishment of the Fund could also have arisen from the omission of the feasibility study to provide for a number of options on the capital and management of the proposed Fund. He indicated that similar institutions had been established in other regions on a more modest scale than that proposed in the feasibility study for the African Monetary Fund.

30. Finally, the Conference decided to expand membership of the Committee for the establishment of the Fund to comprise both the "Libreville Bureau" and the "Blantyre Bureau". The new Committee would also be assisted in technical matters by governors of African central banks, as well as regional and subregional financial institutions. It was also recommended that any member country could volunteer to participate in the work of the Committee. The Conference adopted the resolution on the establishment of the African Monetary Fund which is attached as annex II.

Date and venue of the fourth meeting (agenda item 5)

31. The Conference adopted the recommendation of the Intergovernmental Group of Experts to hold the next meeting of the Conference of Ministers of Finance during the second half of October 1990 at a venue to be decided later.

Any other business (agenda item 6)

32. The Conference reiterated the concerns expressed by the Intergovernmental Group of Experts on the delays in the receipt of documents for the meeting by member States.

Adoption of the report and closure of the meeting (agenda item 7)

33. The Conference adopted its report on 8 March 1989, and was closed by the Honourable Minister of Finance, Mr. Louis J. Chimango, MP, of the Republic of Malawi.

Annex I

THE BLANTYRE STATEMENT OF AFRICAN MINISTERS OF FINANCE ON THE ALTERNATIVE FRAMEWORK FOR STRUCTURAL ADJUSTMENT PROGRAMMES

1. The third meeting of the Conference of African Ministers of Finance convened in Blantyre, Malawi, from 6 to 8 March 1989 to review the proposed African Alternative to Structural Adjustment Programmes: A framework for transformation and recovery (AA-SAP).

2. The meeting, which was attended by Ministers of Finance and plenipotentiaries from 27 African countries as well as by representatives of multilateral financial and development institutions, was officially opened, on behalf of His Excellency the Life President of the Republic of Malawi, Ngwazi Dr. H. Kamuzu Banda, by the Honourable R.W. Chirwa, Minister of Trade, Industry and Tourism. It was also addressed by Professor Adebayo Adedeji, United Nations Under-Secretary-General and Executive Secretary of ECA.

3. The meeting considered at length the AA-SAP proposed by the ECA secretariat and benefitted from the work of the Intergovernmental Group of Experts which had met in Blantyre from 28 February to 5 March 1989 to discuss the same subject. The meeting unanimously commended ECA for having taken such a bold and long-awaited initiative.

4. The meeting generally concurred with the analysis of the structure of the African economy and of Africa's long-term development objectives as defined in the Lagos Plan of Action. It also took note of ECA's assessment of the shortcomings and weaknesses of the existing stabilization and structural adjustment programmes. It was recognized in particular that conventional structural adjustment programmes had failed to take into account the social dimension and global development objectives of Africa.

5. The meeting also found that the overall framework for adjustment with transformation was a sound approach to implementing Africa's development strategy. In fact, while the framework took care of adjustment concerns, it should simultaneously bring about structural transformation. The meeting unanimously agreed that such a framework would go a long way in assisting African countries to articulate their national programmes of adjustment with transformation and to serve as a basis for negotiations with multilateral and bilateral partners. It was therefore considered as an instrument for constructive dialogue with Africa's multilateral and bilateral partners and not one of confrontation. This was confirmed by the fact that although the approach was by and large innovative, it contained some policy instruments and measures that were already being implemented.

6. Notwithstanding the foregoing conclusions, the meeting recommended that ECA should refine the proposal to take into account the following points:

(a) Further refinement of the macro-economic framework of AA-SAP;

(b) Carrying out more indepth studies on the proposed policy instruments and measures such as multiple exchange rates, differential interest rates, selective subsidies and price controls and direct import controls;

(c) Elaborating further on the resource implications of the framework, especially external resources;

(d) Drawing up practical measures for strengthening links among African countries with respect to aspects relating to research, production, trade and finance within the framework of adjustment and transformation;

(e) Further elaboration of the policy instruments and measures to be avoided under AA-SAP.

7. The African Ministers of Finance stressed the need to initiate wide-ranging consultations on the African Alternative. In that regard they agreed on the following course of actions:

(a) A joint meeting of African Ministers of Finance and Ministers of Planning and Economic Development on 10 April 1989 for the joint approval of the revised African Alternative Framework for Structural Adjustment Programmes during the twenty-third meeting of the ECA Conference of Ministers from 6 to 10 April 1989;

(b) Once the document had been finalized and adopted, it should be submitted to the July 1989 meeting of the Working Group of the African Governors of the International Monetary Fund and the World Bank for inclusion in the memoranda to the Managing Director of the IMF and the President of the World Bank as well as the Joint Statement to the Annual Meetings;

(c) Similarly, AA-SAP should be submitted by the African Governors of the IMF and World Bank to the meetings of the Development Committee of the World Bank in September 1989. In that connection, the ECA Executive Secretary should, in collaboration with the Bureau of the Conference, make the appropriate contacts with the Managing Director of the IMF and the President of the World Bank and the African Group in New York; and

(d) Close consultation between ECA, the IMF and the World Bank with respect to the Framework.

8. The meeting further noted that the submission of AA-SAP by the ECA Conference of Ministers to the 1989 second regular session of the Economic and Social Council of the United Nations and subsequently to the forty-fourth session of the United Nations General Assembly would go a long way to focusing the attention of the international community on Africa's stand with respect to policies required for adjustment and transformation.

9. The meeting proposed that after the adoption of the document on 10 April 1989 by the joint meeting of African Ministers of Finance and Planning, the representative to the United Nations in New York, of the Chairman of the joint meeting should transmit the document to the Secretary-General of the

United Nations with a request to include the document as an item on the agenda of the forty-fourth session of the United Nations General Assembly and have it circulated as a General Assembly document.

10. The meeting expressed its deep gratitude to His Excellency the Life President of the Republic of Malawi, Ngwazi Dr. H. Kamuzu Banda, the Government and people of Malawi for providing African countries with this historic opportunity to meet in Malawi and exchange views and experiences on this issue which was crucial to the future economic development of the continent. The generous hospitality and the facilities provided contributed to a large extent to the successful conclusion of the deliberations.

Done at Blantyre, Malawi on 8 March 1989